MANGES (M.) & LILIENTHAL (H.)

A Stenosing Carcinoma of the Transverse Colon.

Excision. Murphy-Button Anastomosis (End to End).

BY

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Julius C., fifty-one years old, salesman, came under my care on May 26, 1894. His family history was negative. For ten years he has had more or less discomfort from his stomach. Two years ago he had a slight left hemiplegia.

His present trouble began fourteen months ago, when he was sick for four months with what was called typhoid fever. After that he was treated for a year for intestinal indigestion. In spite of all treatment and diets, the pains from which he suffered were not relieved, so that for the past five months he has had hypodermic injections of morphine twice daily.

The pains were very variable; they often came on after a good night's rest, even while in bed; sometimes any slight exertion would bring them on. Most frequently they appeared after meals (usually several hours) and preceding or following stools. The pains were colicky in character, and usually began somewhat to the left of the umbilicus, and radiated upward and to the right; when standing, they shot backward. They were always accompanied by a good deal of rumbling in the bowels and the passage of very offensive flatus.

The stools were always constipated, so that he had to resort to cascara and enemata. Formerly they were "crumb-like," but never scybalous or flattened. The evacuations themselves were not painful, except when there was occasionally some rectal irritation from small external hæmorrhoids. There was never any hæmorrhage from the bowels.

In July, 1893, there was continuous vomiting for two weeks. Since then it would occur on very slight provocation, but during the past two weeks this feature has been less marked. No hæmatemesis.

His diet had been restricted, yet he asserts that he could digest his food fairly well, and that what he ate had no effect upon the pains. In fact, he had been kept upon a milk and then on a fish diet for two months, without obtaining any relief from the pains.

His treatment before I saw him consisted of pancrobilin, pancreatin, and all the various ferments, intestinal irrigation, etc.

Examination, May 26, 1894. — The patient is somewhat emaciated, walks bent forward and uses a cane. Heart and lungs negative. The rigidity of the abdominal walls renders examination difficult. Liver and spleen normal. The lower border of the stomach does not reach umbilicus; no succussion. Tenderness, especially to the left of the umbilicus. No glandular enlargements. Spine is not tender; pupils normal in size and reaction; patellar reflexes lessened. Temperature normal. Urine, specific gravity, 1·010; faint trace of albumin; no casts.

29th.—Comes into office with attack. The pain is more stationary to-day and is restricted to the left side of abdomen, and is especially along the colon at the level of the umbilicus. Had retained oil enema all night, but it came away without any stool. Visible intestinal peristalsis and many borborygmi.

June 1st.—For the first time abdomen is soft enough to permit thorough palpation. A distinct hard tumor, about the size of a hen's egg, can be felt in the left umbilical region; it is quite painful and is transversely situated at the level of the umbilicus and about two inches to the left of it. It is freely movable laterally. Marked intestinal peristalsis.

7th.—Inflation of the rectum and colon negative, as the in-

jected air caused so much pain that it could not be retained. The above-described mass can be distinctly felt, and can even be moved to the right of the umbilicus.

10th.—Admitted to my service at the Mount Sinai Hospital. Ewald test breakfast expressed after an hour; 40 c. c. obtained; contains no free hydrochloric acid; faint trace of lactic acid; total acidity, 0·10 per cent. HCl; no starch or dextrin reaction; trace of peptone. Inflation of stomach does not show any marked dilatation.

15th.—Transferred to Dr. Lilienthal's service for operation.

In determining the nature of the tumor several factors would indicate malignancy—viz., the age of the patient, his somewhat cachectic appearance, and the hardness of the mass. On the other hand, the slow growth and the absence of enlarged glands were against this assumption; yet in abdominal carcinomata this is of less significance than it would be elsewhere, for enlarged mesenteric glands are usually beyond the reach of the palpating fingers.

As to its site, the entire clinical picture is that of a stenosis at some point in the intestinal tract, as shown by the colicky pain, the increased peristalsis, borborygmi and constipation. Is the stenosis due to a lesion in the wall of the gut or to the pressure and adherence of some omental growth? The superficiality of the tumor might indicate the latter; but this was evidently not the case here, for there was only a single nodule and ascites was absent. The lateral mobility, also, spoke against the omental location. It was this latter feature, together with the transversely elongated shape, its situation, and the close relation of the colics to the movements of the bowels which led me to assume that the stenosing carcinoma involved the transverse colon. A cicatricial stenosis was excluded by the history and clinical signs.

The results of the analysis of the stomach contents suggested the possibility of the gastric location of the tu-

mor; yet a more careful consideration of all the factors rendered this improbable. Judging from the shape of the mass, the pylorus would be the part involved, for the greater curvature is always infiltrated diffusely and not as was the case here. And if it were indeed the pylorus —the possibility of the pylorus occupying the left umbilical region has been shown by Osler in his recent lectures on abdominal tumors—then a marked gastrectasis with its characteristic symptoms must have been present.

Surgical History of the Case, by Dr. Lilienthal.—On June 11th I saw the patient with Dr. Manges. There was a certain spareness, not amounting to emaciation, and it would have been easy to palpate the abdomen were it not for the sensitiveness and nervousness of the man. Still, a mass as big as an egg could be made out at about the level of the navel. Its long axis was transverse as to patient's body and it could be moved to the right or to the left of the umbilicus for about two inches. It felt hard and was not tender, but after a moment's manipulation there was an intensely painful peristaltic movement with a gurgling as if gas had passed through a very narrow place in the bowel. The patient said that this phenomenon was of constant occurrence on handling the tumor. I agreed with Dr. Manges in his diagnosis and decided to perform abdominal section.

June 18th.—C. was chloroformed and a median cut was made, entering the abdomen from two inches above to about two inches below the navel. The tumor, which just before the operation had been to the left of the median line, could not now be felt, but was soon found well to the right, and on being brought into view proved to be a hard, cicatricial-looking mass in the transverse colon. The omentum, which hung very low, was firmly adherent to the mass. It was at once decided to remove the growth by resecting the diseased gut and its adherent omentum. The mesocolon contained numerous very small nodules, probably secondary to the tumor. The resection was accomplished without difficulty, but the intestinal clamps were not perfectly secure; consequently some fæcal matter escaped

and had to be very carefully wiped away and the surrounding intestines protected with iodoformized gauze. I desire here to acknowledge my indebtedness to the house surgeon, Dr. M. W. Ware, whose care and skill at this stage of the operation were of great value. A large wedge of mesocolon, and that part of the omentum which adhered to the new growth, was also removed, and with it, of course, the entire distal omentum; in all, the greater part of the great omentum. The tumor with four inches of colon was removed, the lines of excision being well in healthy tissue. A large Murphy button an inch and three quarters in diameter was used to approximate the ends of the gut and, as each half of the button took up about an inch more of gut, six inches in all were removed. The button was a very "tight fit" in the colon. The two halves were pressed home as firmly as I could push them, but the mesocolic side formed so thick a mass that the halves of the button were here about one third of an inch apart with the mesocolon and gut tightly wedged between them. On the side of the gut opposite the mesocolon this defect was made up by the spring cup of the Murphy button. This spring gave me some concern, for I feared it might not be strong enough to hold the ends of the intestine well in apposition. At one spot opposite the mesocolon I had not cut the free ends of the gut quite close enough, and, fearing the interposition of a bit of mucous membrane, I broke Dr. Murphy's rule and re-enforced with three Lembert sutures. The excision and approximation of the gut took not longer than six or seven minutes. The abdomen was now completely closed and the patient left the table in fair condition.

On the next day the temperature rose to 102° F., then to 103°+, but there was no vomiting or other evil symptom. The subsequent progress of the case was uneventful. The patient was kept well narcotized until the sixth day, when his bowels were moved by high enema. There was tenderness in the region of the button, which, by the way, could be easily felt through the belly wall as a laterally movable body. After the tenth day full diet was permitted. The pain which was complained of before operation had entirely disappeared.

On the eighteenth day following operation, Dr. T. D. Tuttle, the house surgeon, at my direction performed massage from right to left over the colon. About two hours later an enema was followed by a stool containing the button, which, in spite of its great size, was passed without pain. The following day Mr. C. was discharged from my service recovered.

On August 16th the patient reported himself as much improved in general health. He had gained five or six pounds and looked well. He was still slightly constipated, but his bowels were easily regulated by cascara. There had been absolute freedom from pain.

Examination of the specimen by Dr. F. S. Mandelbaum, assistant pathologist to the hospital, revealed the structure of cylindrical-celled adeno-carcinoma—apparently a degenerated adenoma. It was hard and cicatricial in character and had closed the gut so that its lumen was only large enough to admit a lead pencil.

I can not close this report without adding my testimony to the mass already extant in appreciation of Dr. Murphy's beautiful instrument. The drainage holes and the spring cup guarding against all accident not the result of carelessness make success in enterorrhaphy almost certain.